

A Guide for Navigating India for Future Global Health Teams

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ABSTRACT

Each year, teams of medical students leave British Columbia to take part in Global Health Initiative (GHI) projects. I was in Uttarakhand, India with three other medical students this summer. We experienced several challenges while there, particularly during a 3-day “Train the Trainers” (TTT) workshop where I taught first aid to non-governmental organization (NGO) volunteers. The difficulties I overcame during the first aid course reflected the challenges to be faced by any Western team travelling in India. Hopefully my experiences can help prepare future GHI teams travelling to similar areas. It should be noted that though the following stories are told from my perspective, the work done was collaborative in nature.

KEYWORDS: *global health, education, India*

This summer I took part in a Global Health Initiative (GHI) project in India with three other medical students from UBC. During our first month we held educational workshops for local women and children with non-governmental organization (NGO) volunteers in rural India. At the end of the month, our team met in a central town to carry out a three-day “Train the Trainers” (TTT) workshop on first aid, for which I am a certified trainer. Events during the preparation and implementation of the workshop highlighted cultural difficulties we had been facing since we first arrived in India. Challenges arising from our Western expectations were exaggerated because I approached the first aid course the same way I would have in Canada. While no amount of training could have fully prepared us for what we experienced, hopefully stories about our difficulties will alert future GHI teams travelling to India about the limited availability of resources; the requirement for flexible expectations; the limitations due to language; the meaning of “flexible time”; the inevitability of personal health issues; and the joy of dance and song.

One week before the workshop, we had a conversation with the leaders of the NGOs, Saanvi and Arjun,* about their expectations. Together we created a lesson plan that included all topics they wanted covered while following the Lifesaving Society of Canada requirements as closely as possible. Of the three days we were to spend in the workshop, about two and a half were to be focused around first aid instruction. And so I started to prepare.

Resources were scarce. The day before the workshop began I wandered through the main market, dense with tailors, fabric

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stores, spice and vegetable vendors, and typical, scaled-down convenience stores. With no portable defibrillators or compressible mannequins, I had to use what was available: saris for triangular bandages, size 7.5 surgical gloves, and acetylsalicylic acid (Aspirin) and nitroglycerin (no prescription needed) from the chemist to teach about treating bleeds and heart attacks. I emptied the available stock of stuffed dolls from three stores to have enough to teach infant CPR. Towels and sheets from the hotels served as makeshift splints and emergency carry blankets, and a plastic syringe was used for simulated scenarios. This equipment was not quite to Canadian standards, but it would have to do. Having flexible expectations had been important throughout the trip and was necessary here, even before the course started.

Aside from equipment, the planning phase of the workshop was no different than what we would have expected in Canada. The TTT workshop began with a brief introduction with some icebreakers for the 23 attendees in the room. Following this was our first cultural-social challenge. Saanvi and Arjun, with whom we had met twice previously to plan the workshop, asked the volunteers, “What would you like to learn in this workshop?” To involve their volunteers, Saanvi and Arjun were starting the planning from scratch.

For ten minutes, the volunteers proceeded to name topics of interest, none of which included first aid. Interesting medical conditions, nutritional advice, ideas for games, and many other

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Photograph 1: An NGO volunteer practicing CPR. Photo credit to Charlie Walsh.

suggestions that we hadn't planned for were discussed, with the implication that we would be teaching whatever was brainstormed at that time. What's more, neither Saanvi nor Arjun attempted to guide the discussion towards the things we had already planned. All we could do was hope that the group ended up suggesting something on our lesson plan.

And they did. One of the volunteers mentioned that she would like to learn about snake bites. In my panic, I jumped on that suggestion and desperately asked the group if they wanted to learn about that and more. I suggested the full gamut of first aid instructing because I was a first aid instructor from Canada. To our collective relief, they embraced my suggestion. With that, for the next 20 hours our team was able to actually follow through with what we had planned to do.

Up until this point in our trip to India, we had constantly been exposed to the need for having flexible expectations. Whether it was our departure time in the morning or the day's destination, planned activities changed constantly, and we had begun to get used to it. However, the Western addiction to plans overcame us in this instance, as I completely expected the workshop to happen without a hitch. It was a lesson we were being reminded of up until our last day in India.

The impact of having to work through translation created challenges that required adjustments to the instruction techniques. Teaching the concept of agonal breathing via a translator was nearly impossible. Perfecting the technique of opening the airway with a head-tilt jaw-lift took four times longer than anticipated. Usually I ask my students to verbalize their steps to test their confidence. However, imagine 13 students, shouting instructions on how to call 911 (101 in India) in Hindi to an imaginary bystander, all at once. Clearly, I needed to adjust my technique. I had assumed a translator would remove all confusion from

the sessions. Upon reflection, though, when "translators" were provided at any point in our trip, they were seldom fully fluent in English. This difficulty was exacerbated when we were teaching a topic with which they were unfamiliar (like first aid). Regardless of the preparations taken, language was always an issue for us and will be for any other teams. Once we realized this, making adjustments to instruction with respect to speed, body language, and vocabulary helped immensely.

By the second day, I realized that hands-on skills were much easier to translate. Teaching about responding to drowning emergencies in a very dry room (save for the occasional chai) or the theory behind contralateral paralysis in stroke patients wasn't creating large returns on my instruction. The Heimlich maneuver, infant CPR, emergency splints, slings, and carries, on the other hand, were picked up almost as quickly as if the course was taught in Canada. Flexibility, again, was pertinent.

Throughout all this, the cultural challenge of working in "flexible time" pervaded. I quickly realized that a 16-hour course in Canada with English speakers takes at least 24 hours in India. This isn't exclusively due to the translation. A local told us that "flexible time" is an endearing and frustrating concept in India. Thankfully, we experienced this the minute we landed in Delhi, so we were able to take it in stride. We knew that a set 900h start time could easily mean 1030h. The hour for lunch would reasonably stretch to two. The timing of the class only worked because I practiced the lessons about flexibility that I'd learned in the previous month.

Then there was the "intestinal challenge." By the third day, I was teaching while on an inappropriately large regimen of bismuth subsalicylate (Pepto-bismol) and loperamide (Immodium). Taken to prevent any interruptions in the class, it is one thing that every traveler to India should factor into their schedule. With regards to diarrhea, travel doctors told me, "It's not if, it's when." The sooner you realize that your bowels can control your schedule while travelling, the quicker you will be able to adapt when they do.

A cultural difference that turned out to be a cultural joy transpired at the end of each meeting day, when we wrapped up in true Indian fashion: with entertainment. For one hour to conclude



Photograph 2: Jesse Ory demonstrating opening the airway on another team member, Nicole Perkes. Photo credit to Charlie Walsh.

each day, all 23 NGO volunteers and the NGO heads participated in song and dance. Beginning without any preamble or questioning, everyone formed a circle and proceeded to spontaneously sing songs. And, in random but thorough sequence, every member of the group—even the NGO heads—was encouraged and insisted upon entering the circle to dance solo for the amusement and enjoyment of the rest. Thankfully two other men who knew how to dance accompanied me, and my awkwardness and inability to gracefully move my hands were excused. We were lucky to have been forewarned about the singing and so had prepared two or three songs of our own to contribute. This is the one thing that can be prepared for, so take heed! Any foreigners who travel to India will find themselves sorely removed from festivities unless they have something in their back pocket that they can perform.

In light of the cultural and social differences we faced during the three days, the course was a success. Only by being flexible with translation and time and releasing our Western grip on expectations were we able to truly enjoy the experience.

For future teams, this shift in mindset is essential to functioning abroad. Each individual must accept that everything will be slow. Language will be a barrier. Resources will be scarce. Plans will change, and expectations must be put aside. Entertainment as a unifier will be an essential element of group bonding. These are the skills and realizations that took us months to hone, and despite our shortcomings illustrated above, the first aid course achieved its goals. We were able to change some misconceptions and had a chance to experience the unique qualities India offers foreigners before returning home. 

*Names have been changed for this article.

ACKNOWLEDGEMENTS

The author would like to thank Nicole Perkes, Charlie Walsh, Julia Wei, and Dr. Videsh Kapoor for their assistance in compiling this article.

Why Med Students Should be Heated Up about Climate Change

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ABSTRACT

Future climate change is predicted to have a devastating effect on human health, with attributable morbidity and mortality already occurring. Climate-sensitive diseases such as malnutrition, diarrhea, vector-borne illnesses, and cardiovascular and respiratory disease are projected to increase, mainly in populations with an already high disease burden. Ironically, those who are most vulnerable are those who contribute the least to global greenhouse gas emissions. As health care professionals we can serve a unique role in national and international climate change policy and reduce emissions by promoting lifestyle choices that co-benefit health.

KEYWORDS: *climate change, environmental health, global health, climate-sensitive diseases*

INTRODUCTION

In 2009, climate change was declared the biggest global health threat of the 21st century.¹ A startling statement, especially since it didn't arise from some left-wing blog post, but from one of the grails of peer-reviewed medicine. For me, this was a big moment—I expected that the health community would embrace the challenge and become a leader in climate change advocacy. Naively optimistic, no? After two years of medical school, I chose to supplement my non-existent training through an internship with the Climate Change and Human Health team at the World Health Organization. I was quickly humbled by my lack of appreciation of how a changing climate permeates throughout human life, and

the real scale of the problem. I provide here a synopsis of what I have learned: the global health effects of climate change and what we as future health care professionals can do about it. Hopefully, it will be enough to raise your temperature a few degrees.

Addressing the Elephant

To begin, a big question needs to be answered: is climate change real? The Intergovernmental Panel on Climate Change (IPCC), which draws expertise from thousands of scientists from nearly 200 countries, states that 'climate change is unequivocal' and that most of the warming seen since 1950 is due to greenhouse gases from human activities.² This verdict is echoed in the scientific community by all major environmental-science bodies in the USA and Canada, and the vast majority of peer-reviewed articles on climate change.³ Public perception, while often shown as polarized in the media, also reflects this viewpoint: a 2012 study

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